§ 58-89A-106. Health insurance plan requirements.

(a) In order for a licensee to sponsor and maintain a health benefit plan that is not fully insured by one or more of the entities specified in subsection (a) of G.S. 58-89A-105 on and after October 1, 2009, as authorized by subsection (e) of that section, the licensee shall meet all of the requirements listed in this subsection. A health benefit plan developed under this section is not required to provide coverage that meets the requirements of other provisions of this Chapter that mandate either coverage or the offer of coverage by the type or level of health care services or health care provider. The licensee shall:

(1) Use a third-party administrator licensed or registered under Article 56 of this Chapter.

(2) Hold all health insurance plan assets, including participant contributions, in a separate trust account for use only with the health benefit plan.

(3) Provide sound reserves for the health benefit plan that are determined on an annual basis by an actuary who is a member in good standing of the American Academy of Actuaries. The Commissioner may establish, by rule, a process for approving plan reserves.

(4) Maintain the health benefit plan for only employees of the licensee or employees of the client company and neither offer nor advertise the health insurance benefit plan to the public generally.

(5) Issue to each covered employee a policy, contract, certificate, summary plan description, or other evidence of the benefits and coverages provided. The evidence of benefits and coverages provided shall contain, in boldface print in a conspicuous location, the following statement: "THE BENEFITS UNDER THIS PLAN MAY NOT BE EQUAL TO THE MANDATED BENEFITS REQUIRED OF FULLY INSURED PLANS. THE BENEFITS AND COVERAGES DESCRIBED HEREIN ARE PROVIDED THROUGH A SELF-FUNDED HEALTH BENEFIT PLAN ESTABLISHED BY [name of PEO]. EXCESS INSURANCE IS PROVIDED BY AN AUTHORIZED INSURANCE COMPANY TO COVER HIGH AMOUNT MEDICAL CLAIMS. THE HEALTH BENEFIT PLAN IS NOT PROTECTED BY ANY INSURANCE GUARANTY ASSOCIATION. OTHER RELATED FINANCIAL INFORMATION IS AVAILABLE FROM YOUR EMPLOYER OR FROM THE [name of PEO]." Any statement required by this subsection is not required on identification cards issued to covered employees or other insureds.

(6) File all contracts with third-party administrators with the Commissioner and report any changes to those contracts to the Commissioner before their implementation.

(7) Obtain and maintain stop-loss insurance from an insurer authorized to write insurance in this State and that meets the following requirements:

a. If individual stop-loss insurance, it is actuarially appropriate for the size of the group, surplus, and the expected losses, as determined by a qualified actuary and approved by the Commissioner.

b. If aggregate stop-loss insurance, it is actuarially appropriate for the size of the group, surplus, and the expected losses as determined by a qualified actuary and approved by the Commissioner. If the licensee is unable to obtain aggregate stop-loss insurance that is actuarially appropriate, the licensee shall maintain at least a thirty percent (30%)

lag reserve above expected losses, as determined by a qualified actuary.

c. If prescribed by the Commissioner, by rule, it satisfies net retention levels in accordance with a PEO's surplus and expected claims.

(8) File with the Commissioner for information the summary plan description and the evidence of the benefits and coverages provided under the health benefit plan that is issued to the person covered by the health benefit plan.

(9) Establish and maintain a written plan of operation for the health benefit plan.

(10) File with the Commissioner the plan of operation for the health benefit plan and any updates to the plan of operation within 30 days of implementation.

(11) Upon request of the Commissioner, provide information that summarizes paid and incurred expenses and contributions or premiums received and any additional evidence that the PEO's health benefit plan is actuarially sound.

(b) Notwithstanding Chapter 132 of the General Statutes, all documents filed by a licensee under this section are confidential, are not open for public inspection, and are not discoverable or admissible in evidence in a civil action brought by a party other than the Department against a person regulated by the Department, its directors, officers, or employees, unless the court finds that the interests of justice require that the documents be discoverable or admissible in evidence. The Commissioner, however, may use the contracts filed under this subsection in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties. (2009-552, s. 3; 2010-96, s. 11.)